



Government of
Saskatchewan



Our Children. Our Promise. Our Future.

Early Childhood Development Progress Report 2004/2005

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national
children's agenda



Message from the Ministers



Children are our most precious resource. It is well understood that the earliest years of life are the most critical to success in adulthood. The Government of Saskatchewan is committed to providing our Province's young children, and their families, with the support and encouragement they need to thrive.



Over the past 10 years, the Government of Saskatchewan has placed increasing emphasis on building a range of supports for vulnerable children, prenatal to age five, and their families. The KidsFirst Program brings together resources and knowledge from a variety of sectors to provide a co-ordinated, comprehensive approach to assist families to nurture their children. Coordinated through the Departments of Health, Learning, Community Resources, and First Nations and Métis Relations, the program supports and builds on existing programs and services for vulnerable children.

Early childhood development initiatives are linked to early learning and child care. Our goal is that children will have the best possible chance to get a healthy start in life. All children should have the best possible early learning and child care experiences, and families should have support and assistance in their communities. The Province will continue to work toward this goal.

The Early Childhood Development Progress Report 2004-05 describes the progress made to bring about a positive difference in the lives of Saskatchewan's youngest citizens. We believe that all children deserve the best possible start in life and that the investment in the early years is a sound investment in Saskatchewan's future.



Buckley Belanger
Minister of Community Resources and Employment



Deb Higgins
Minister of Learning



Graham Addley
Minister of Healthy Living Services

Early Childhood Development Overview

The Early Childhood Development (ECD) strategy is a major interdepartmental initiative of the Government of Saskatchewan, with funding provided through the 2000 Federal/Provincial/Territorial (F/T/P) Communiqué on ECD.

Of all the investments a society can make for its future, the nurturing of young children is perhaps the most crucial. Investing in the development of children in their earliest years ensures that children have the best possible start in life to develop the skills and abilities they need to thrive. Research shows that the quality of experience children have early in life is significant to their long-term success and happiness.

In 1997, the Province identified early childhood development as one of five social priorities. Responsibility for the development of an ECD Strategy was assigned to the Ministers of Health, Learning and Community Resources. An ECD Strategy was developed by an Interdepartmental Steering Committee and approved by the Government in October 1998.

As a result of further work, in 2000 the Province directed that early childhood programs focus on the development of services for children, age prenatal to five, and their families, who are at the greatest risk due to socio-economic circumstances. Emphasis was also to be placed on programs targeted at vulnerable pregnant women in order to prevent developmental delays in their children.

Concurrent with these developments in 2000, First Ministers across Canada agreed on early childhood development as a F/P/T priority. The F/P/T agreement was reached in September 2000, providing federal funding for new or enhanced provincial early childhood development programs for a five-year period starting in 2001-02. In the 2003-04 federal budget, the commitment to the program was extended for a further two years, through 2007-08.

Under the F/P/T Communiqué on ECD signed in September 2000, the federal

government committed to funding the provinces for new and enhanced early childhood development programs and services in four key areas:

- Promoting healthy pregnancy, birth and infancy;
- Improving parenting and family supports;
- Strengthening early childhood development, learning and care; and
- Strengthening community supports.

The provinces committed to:

- The expansion or development of new early childhood development programs in their jurisdictions in the above four broad areas;
- Annual public reporting on expenditures and progress in relation to the federal funding; and
- Incremental provincial funding as resources permitted.

Prevention and Early Intervention

The focus in early childhood development is on the quality of experience and care in children's early years which influences outcomes in later years. Current research in neuroscience has demonstrated that there is a strong link between brain development and early environmental influence. Most of the 'wiring' in the human brain that supports lifelong learning, behaviour and health is in place by the age of six (Guy, K.A. (ed.) (1997). *Our Promise to Children*. Ottawa: Canadian Institute of Child Health).

Ultimately, the effects of negative early childhood experiences can be cumulative and become evident in problems with cognitive, emotional, physical and social development. These problems are not as visible in the child's early years, but may require intervention at a later time. Intervening early is the most effective means of addressing children's developmental needs and results in the most significant benefit in the long-term for children.

Early Childhood Development Overview (Continued)



Prevention and early intervention result in long-term, beneficial effects in later life, such as improved educational attainment and performance, increased employment, improved social skills, reduced involvement in the criminal justice system, and better health. In a strategic plan for early childhood development, and specifically KidsFirst, there are many trends and issues that must be considered in order to be effective in making a difference for vulnerable children.

Vulnerable Children and Families

There are a number of social and/or economic circumstances that are detrimental to a child's development and well-being. The exact extent of children and their families who live in very vulnerable circumstances in Saskatchewan is not currently known. However, the magnitude of vulnerability can be estimated by looking at the proportion of low-income families.



Children from families that are at or below the poverty line are at significantly higher risk for negative childhood outcomes due to environmental factors. 'Poor children are not always disadvantaged and disadvantaged children are not always poor. According to the National Longitudinal Study on Children and Youth, positive parenting, nurturing neighbourhoods and high-quality child care may decrease the chances of developmental problems in children.' (Toward a Healthy Future, Second Report on the Health of Canadians, Healthy Child Development, Federal, Provincial and Territorial Advisory Committee on Population Health, 1999).

Children in low-income families are more likely to:

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- Live in substandard housing, problem neighbourhoods and poorly functioning families;
 - Demonstrate high levels of aggression;
 - Have health problems and delayed development; and
 - Not participate in cultural and recreational activity.

Low-income families are characteristically:

- Young (24 years or under);
- With a female head of household;
- Not married (single or other);
- Unemployed or work less than 40 hours per week and in low-paying jobs;
- Poorly educated;
- Consisting of mothers with one or more children;
- Socially isolated from community supports;
- Suffering from addictions; and
- Prone to violence within their families.

It is crucial to Saskatchewan's future that children and their families have access to supportive, respectful, and culturally relevant early childhood development programs. In providing early childhood development policy and programs, the Government of Saskatchewan is committed to meeting the needs of children and their families.

Early Learning and Child Care

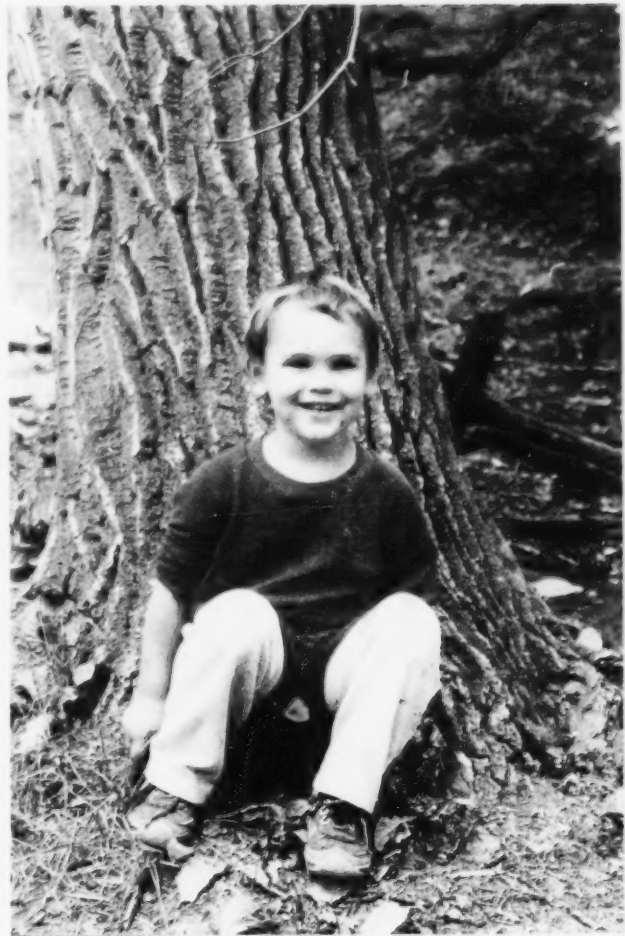
Saskatchewan supported the 2003 Multilateral Framework on Early Learning and Child Care as an important step in providing further early childhood development supports and services.

Saskatchewan's immediate response to the framework was to use a significant portion of the federal funds to support *Child Care Saskatchewan* - the largest expansion of licensed child care in Saskatchewan history. The *Child Care Saskatchewan* initiative is a four year plan to develop 1,200 licensed child care spaces,

In the first year, 2003-04, Saskatchewan added provincial funding to the \$800,000 federal money to kick-start the initiative with the development of 500 new child care spaces in year one, and to increase child care subsidies by an average of \$20 per child per month. Capital funding was also provided to support the development of the new spaces.

In 2004-05, an additional 227 licensed child care spaces were added in the province as part of *Child Care Saskatchewan*. Capital funding was once again provided. As well, the Early Childhood Services grant to child care centres was increased by \$10 per month per required staff, in order to support increased early childhood educator wages.

The 2003 Multilateral Framework on Early Learning and Child Care provided Saskatchewan with \$4.7M in federal funding in 2004-05, of which \$3.8M was committed and spent on the *Child Care Saskatchewan* initiative. This federal funding will grow to \$9.2M in 2006-07, and \$10.6M annually thereafter, with about half uncommitted and available to be invested based on future planning in early learning and child care.



PreKindergarten

In 1996-97, Saskatchewan Learning's Prekindergarten program was established in partnership with school divisions that participate in the Community Schools Program. In 2004-05, there were 104 prekindergarten programs supported by Saskatchewan Learning and provincial school divisions, with up to 16 children in each program.

Prekindergarten is targeted to three and four year olds. Drawing on Saskatchewan's kindergarten curriculum as its foundation, the program incorporates additional elements and adapts others to meet the needs of very young children living in vulnerable circumstances.

Specifically, early intervention prekindergarten focuses on:

- Fostering social development and self esteem;
- Nurturing educational growth and school success;
- Promoting language development; and
- Involving families.

In 2004-05, \$200,000 of Early Childhood Development funding was allocated for prekindergarten programs. Using social, health

and economic indicators, four communities with significant numbers of vulnerable preschool children were selected: Estevan, Melfort, Swift Current and Weyburn. Individual communities received \$50,000 annually to operate the program. Additional support services offered through prekindergarten in 2004-05 included: parent supports, transportation, speech and language, nutrition, dental and public health, family literacy, music and swimming programs.



Early Childhood Intervention Program

In Saskatchewan, Early Childhood Intervention Programs (ECIPs) were established in the early 1980s to provide home-based support to families of children with disabilities or to prevent delayed development. The focus of the intervention is to:

- Educate parents on the nature of their child's disability;
- Develop an intervention plan in conjunction with the parents; and
- Assist parents to implement the intervention plan to maximize their child's development from birth to age five.

Interventionists also assist in the transition to school. They work closely with teachers and parents to assist in developmental and educational plans.

There are 16 community-based, non-profit ECIPs in Saskatchewan. Fifty-five interventionists serve 696 children, birth to school age, and their families. These interventionists meet with families in their homes approximately twice a month to develop an intervention plan and provide ongoing support, monitoring and assessment. As well, they provide a valuable link between families and other professionals such as speech and language pathologists, physiotherapists, occupational therapists, teachers, nurses and medical specialist. Many parents have commented on their appreciation for these interventions as they tie together a daily support and intervention plan for their children.



Ongoing funding for 108 additional spaces has been provided in each of 2002-03, 2003-04, and 2004-05. The following agencies were provided funding for spaces: Meadow Lake and Area ECIP; Battlefords ECIP; Prince Albert ECIP; South East ECIP; Alvin Buckwold ECIP, Saskatoon, Inc.; Swift Current and District ECIP; Parkland ECIP; Children North ECIP; and Wecihik Awasisak Help the Children, Ile a la Crosse.

Infant Mortality Risk Reduction Initiatives

In Saskatchewan and across Canada, infant mortality rates have dropped significantly during the last 20 years. In 1985, the infant mortality rate in Saskatchewan was 11.0 per 1,000 live births. In 2004, the provisional figure was 5.9 per 1,000 live births. In 2003-04, the infant mortality risk reduction initiatives continued to promote healthy pregnancy and birth as well as healthy infant development.

In 2001-02, Saskatchewan Health identified five health regions that had high infant mortality rates and limited program and resource support:

- Mamawetan-Churchill River;
- Keewatin Yatthé;
- Heartland;
- Prince Albert Parkland; and
- Athabasca Health Authority.

In 2004-05, the regions continued with the activities beginning in 2002-03, including:

Northern regions:

Nutritional support for high risk prenatal mothers to increase their awareness and skill development in the area of prenatal, infant and general nutrition, food preparation, economical shopping for healthy foods, as well as general prenatal education in the areas of prenatal health issues, breastfeeding, alcohol and smoking avoidance in the five targeted communities of Cole Bay / Jans Bay, Stony Rapids and area, Buffalo Narrows, Sandy Bay and Pinehouse – communities that do not have access to the Canadian Prenatal Nutrition Program.

All three northern regions delivered capacity building sessions for related health workers and improved resource material access for mothers. The planning, coordination and delivery of the above were achieved through partnership with the Saskatchewan Prevention Institute and the Perinatal Education Program of the Colleges of Nursing and Medicine at the University of Saskatchewan.

Prince Albert Parkland:

The focus was a Parent Support Program for prevention of infant mortality. Through a combination of home visits and community programming, the Parent Support Program Coordinator offered support and education to caregivers and their families with a goal to optimize pregnancy outcomes, ensure positive childhood growth and development, as well as to optimize healthy parental lifestyle choices.

Breast-feeding initiatives for mothers were organized through a lactation consultant and a Breast-Feeding Initiatives Implementation Committee. Breastfeeding has a major role in maternal and child health and is known to be a key factor in reducing levels of infant mortality.

Heartland:

Planning and development to increase targeted programming for adolescents and young parents on topics relevant to current health and lifestyle issues, pregnancy prevention, parenting, healthy relationships, injury prevention, substance use and abuse, and overall wellness.

These activities are ongoing and are expected to have a positive impact on the general health of infants in these regions and to contribute to a reduction in the risk of infant mortality in Saskatchewan.



KidsFirst Program Progress 2004-05

Saskatchewan's KidsFirst Program, announced by the Government in April 2001, is a key interdepartmental initiative designed to support vulnerable families in nurturing their children. The program is based on prevention and early intervention initiatives that focus on providing services for children prenatal to age five, and their families, who are vulnerable due to their social and economic circumstances. Emphasis is also placed on the prevention of Fetal Alcohol Spectrum Disorder (FASD). This approach is founded on the knowledge that our overall health, well-being and resiliency as adolescents and adults is strongly influenced by the quality of our early years' experiences.

KidsFirst services support the healthy growth and development of vulnerable children by providing intensive supports to families in nine communities across the Province where the need is greatest – that is, where the greatest concentration of vulnerable families exists. The nine targeted communities that receive KidsFirst funding are: Meadow Lake, Moose Jaw, Nipawin, the North, North Battleford, Prince Albert, Regina, Saskatoon, and Yorkton.

Other communities in Saskatchewan also benefit from improved integration of existing services. Early childhood community developers work with community stakeholders and partners to develop an inventory of currently available services, establish partnerships and protocols for referrals from the Birth Screening Program, determine the capacity of the community to provide services to vulnerable families, and assist the community to realign services to address unmet needs.

KidsFirst components include:

- Prenatal – works with pregnant women to ensure they are receiving nutritional supplements, prenatal education and appropriate medical care
- In-hospital screening – newborns and their families participate to allow service providers to maximize benefits to families

- In-depth assessment – families participate to allow service providers to focus efforts for maximum benefit
- Home visiting – supports KidsFirst families to enhance the development of their children
- Early learning opportunities – children participate to enhance learning
- Access to child care – enables families to participate in skills training and the work force
- Dedicated mental health and addictions services – meets families' needs
- Community-based supports – enhances family knowledge, including literacy, child development skills, social networks and nutrition education

Program Highlights

Participation in KidsFirst continued at a steady rate in 2004-05, with 875 families participating in the program at year end, and more than 1,600 families accessing the program during the year. Detailed information on key actions is contained within the KidsFirst Strategy Annual Report 2004-05 available at www.sasklearning.gov.sk.ca/branches/ccd.

According to recent research, home visiting services that are offered as stand-alone services typically do not produce large, easily-observed changes with the families they serve. However, programs that offer more holistic approaches, especially home visiting services in conjunction with centre-based early learning and child care, appear to produce larger and more long-lasting results, notably for child cognitive development and school achievement (Gomby, Deanna (2005). *Home Visitation in 2005: Outcomes for Children and Parents*. Committee for Economic Development, Invest in Kids Working Group, www.ced.org/projects/kids.shtml). This holistic approach is part of the KidsFirst Strategy.



Encouraging stimulating environments, play based learning, and supporting KidsFirst children with special needs promotes healthy child development. Research indicates the importance of integrating early learning, child care and parenting support elements to improve children's ability to learn. Some of the families within the KidsFirst program also identify structured care and learning environments outside the home as an initial necessary support while they address their own social or economic challenges.



Client families, both pre- and post-natal, received support and education on early childhood development activities through the home-visiting component of the program. Families also had opportunities to participate in programs directed at early childhood development and learning. All KidsFirst targeted communities provided funding to enable enhancements to community-based early learning and child care.



Injuries are a significant cause of hospitalization of children. It is important for families to have access to information that enables them to ensure that their home is safe. Engaging families in activities that will help address home safety and security issues is important in order to establish a home environment that is as safe as possible. In many cases, client families are unaware of the safety risks they can control. Education by the home visitors provides a major influence on change in this area. Activities include such things as child proofing cupboard doors, removing sharp or dangerous objects from play areas, use of safety plugs in outlets, providing working smoke detectors, use of car seats, and requesting landlords to repair structural features that are a safety risk.



All communities provided education and activities related to housing and home safety. In one community, over 500 people took part in an interactive afternoon that focussed on fire prevention and safety within the home. This event, sponsored by the fire department, in addition to providing safety information, also



strengthened community relations between the service providers and the families.

Parent support programs are important vehicles to address social inclusion. KidsFirst communities have made great efforts in linking the families with available community support networks. Additionally, KidsFirst provides programming such as women's support groups, men's support groups, social and special event group functions, prenatal groups, gym nights, and numerous others. These social events provide opportunities for families to increase their social support networks, and importantly, may have educational components, child development components, family mental health and relationship components included in the event.

Enhancing education, training and skill development is essential to improved labour force attachment and improved self-esteem. KidsFirst has no direct influence on income levels, but provides some of the conditions and encouragement that can help stabilize and increase the opportunities for this population. Supports provided include transportation and child care, assistance enrolling in programs, and information on opportunities available and accessible to the KidsFirst families. In 2004-05, at least 505 families participated in programs aimed at skill development, education upgrading, and literacy programs.

Increasing food security is an objective of the KidsFirst program. Families are encouraged and supported to utilize Good Food Box programs, Family Basket, food banks, community kitchens, diabetic cooking groups, and other supports available in the community. KidsFirst communities also provide access to budgeting workshops, education on nutrition and grocery shopping, as well as transportation. Additionally, community garden projects are supported and food is provided at early learning and child care settings. In some circumstances, KidsFirst also advocates for emergency and ongoing food funding and support with service provider agencies.

The goal of KidsFirst is to close the gaps in the service system that exist for vulnerable families and address the circumstances that prevent them from being able to function effectively in mainstream society. Responses are tailored to provide only those supports that address each family's needs and build upon family strengths. The goal is for families to reach a level of strength and independence, as well as become linked with available services and support networks in their communities, without the need for further intensive supports such as KidsFirst.



When Shannon moved to Moose Jaw she was a single mother of a toddler and pregnant. She returned to high school and continued until her graduation in June, 2005. Shannon has now entered into post-secondary education.

Home Visitors:

'Some days I feel like they cannot pay me enough to do this work, and some days I feel I cannot believe they pay me to do this work.'

'Because of the work I do with my families, I see them as more educated now about their personal health and their children's health in terms of immunizations and prenatal

checkups. I have families who never went to the doctor and now are going on a regular basis with their children.'

'I take developing relationships very seriously. There are different traditions in Aboriginal culture. I work at learning what their family tradition is.'



Moms:

'I am 21 years old. I have taken part in the Circle of Learning Diabetes Prevention Activities and promotions, healthy living food experience, educational training provided by Battlefords Family Health Centre or BTC – Indian Health Services, including Leadership Saskatchewan, and the Life Skills Center for Leadership. I am also a KidsFirst family and use the Good Food Box program.'

'These programs changed my life. They showed me and encouraged me to be the best person I can be, in my lifestyle and in what I do or eat. They helped me choose a healthier life for my family and myself. The message they left with me was that I can make changes in my life – it was all up to me. The choices I make will make a difference.'

'With my daughter, they showed me how to communicate with her, different ways to play and teach her. These programs helped me make healthier choices for her life. She is the reason I take these programs so I can be the best mother for her. I try to practice those activities every day.'

'My home visitor helped me to make good changes. She started me on my healthy living path. She showed me that I can make mistakes and that it is okay. I did not have too many friends when I had my baby, but through these programs, I have made friends and family. She showed me that I can be the best. She is more than a friend; she is a friend for life. Everyone has problems – how we deal with them is how we change our lives.'

'When I was in the system, I felt oppressed, not supported, and unheard. I wasn't even allowed to make a change. KidsFirst has provided me with the support to change.'

'My home visitor always helps me. She has been accepting and non-judgmental of me, even when I admitted I was an addict. She challenged me to explore things further. I came from an abusive family and didn't want that for my kids. KidsFirst is helping me break the cycle. It takes one person to break the cycle, and I want to be that person.'

'There are several Native students graduating today and I hope we inspire other Native people to follow our footsteps. Education is really necessary to function in today's world. I've learned that obstacles are those frightening things you see only when you take your eyes off your goal. So keep looking forward, keep working and keep believing. You will succeed.'

Summary of Investments 2001-02 to 2004-05

The following table outlines the changes in investment from 2002-03 through 2004-05 for the ECD Strategy. To the end of 2004-05, the expenditure through the ECD F/P/T Framework Agreement has totalled \$43.1 million over four years.

Program Area	2001-02	2002-03	2003-04	2004-05
KidsFirst				
Non-Targeted Communities	637,000	0*	618,000	637,000
• Universal newborn screening • Realignment of existing programs				
Targeted Communities	3,119,000	6,754,000	9,805,000	12,100,000**
• Prenatal screening and outreach • Birth screening and assessment • Home visiting • Mental Health and Addictions • Enhanced Child care • Early learning programs • Parenting supports				
Program Support	880,000	590,000***	677,000	659,000
Child Care	1,019,000	1,019,000	1,019,000	1,019,000
• Training, wage enhancement and start up grants				
Early Intervention Spaces	370,000	370,000	370,000	370,000
PreKindergarten Program	200,000	200,000	200,000	200,000
Infant Mortality Initiatives	95,000	71,000	70,000	51,000
TOTAL	6,320,000	9,004,000	12,759,000	15,036,000

* Expenditures for 2002-03 were expensed in 2001-02.

** Includes \$100,000 provided as additional support under the Cognitive Disabilities Strategy

*** The figure reported in the 2002-03 Progress Report was \$646,001.

Investments in Early Learning and Child Care - 2002-03 to 2004-05

1. Spaces

Child Care:	2002-03	2003-04	2004-05
Number of licensed centres:	138	153	158
Number of licensed centre spaces:	5,123	5,540	5,768

Type of Centre Space:

Infants:	357	452	498
Toddlers:	980	1,129	1,206
Preschool:	2,949	3,085	3,162
School Age:	837	874	902
Total:	5,123	5,540	5,768

Number of licensed family child care homes:	277	291	287
Number of licensed family child care spaces:	2,160	2,370	2,369
Total Number Of Licensed Child Care Spaces:	7,283	7,910	8,137

Prekindergarten:

Number of programs*:	89*	104*	104*
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*Includes four programs financed through federal ECD serving 66 children and families.

Number of spaces:	1,300*	1,661*	1,666
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*Based on an average of 16 spaces per program.

Early Entrance Designated Disabled Pupil Program

Number of children:	289	307	230
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2. Child Care Subsidy

	2002-03	2003-04	2004-05
Average number of subsidies:	3,353	3,408	3,518
Average monthly subsidy:	\$239.96*	\$254.64	\$264.70
Total Subsidy:	\$ 9,409,000	\$10,414,000	\$11,183,000

*Previously reported as \$241.92

3. Grants

Grants For Child Care Programs:	2002-03	2003-04	2004-05
Early Childhood Services Grants: * Plus \$869,000 ECD	4,440,773*	5,271,737*	5,827,826
Teen Support Grants:	732,345	873,284	995,440
Preschool Support Grants:	503,950	507,551	508,434
Start Up Grants: * Plus \$15,000 ECD	152,900*	206,080*	141,500
Home Equipment/Programming Grants: * Plus \$50,000 ECD	129,134*	134,090*	149,634
Special Northern Allowances:	18,760		38,685
Community Solutions Grants (rural, workplace, special needs, etc.):	610,117	701,662	857,329
Training /Education Grants: * Plus \$85,000 ECD	9,027*	4,393*	2,980
Special Needs Grants:	1,414,756	1,606,358	1,683,775
Total Child Care Grants: * Plus \$1,019,000 ECD	8,011,762*	9,674,451*	10,321,452*
Capital Grants		416,574	165,849

Child Care Administration

Administration (licensing and subsidy):	\$1,826,371	2,013,983	1,933,070
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*Note: 2002-03 figures have been updated - varies from previous reports.



Indicators of Child Well-being in Saskatchewan

The primary influences on children occur within families. Families are shaped by the physical and community environments in which they live. Families are more likely to be healthy if they live in healthy communities where it is 'easy' to be healthy. Do people have enough income, education, support from family and friends, or healthy environments? Research is providing evidence that growing up in a community that is perceived to have higher levels of cohesion, stability and social supports will lead to healthier child development. A growing number of comparable indicators are available for governments to use in a number of areas of interest – physical health, early development, safety and security, as well as family and community well-being.

In September 2000, First Ministers released a communiqué on early childhood development. As part of the public reporting commitments outlined in the communiqué, they agreed that governments would 'make regular public reports on outcome indicators of child well-being, using an agreed upon set of common

indicators.' For 2004-05, Saskatchewan will report on 23 indicators of child well-being.

This report presents the information relating to the indicators and their performance as indicators of child well-being in general terms only and is not intended to provide an analysis of the data.

Saskatchewan child well-being is either consistent with, or can be favourably compared to, the national average in many areas. However, there are some indicators that are of concern. For example, there is a higher incidence of injury hospitalization, tobacco use during pregnancy, and low income rates when compared to the national average. Public health analysts monitoring this data have highlighted these concerns for several years. It was concern over these negative indicators that, in part, led the Province to create the long-term preventative vision contained in the Early Childhood Development initiative.

Common Indicators of Child Well-Being

Physical Health

- *Healthy birth weight - high or low*
- *Immunization*
 - *Meningococcal disease*
 - *Measles*
 - *Haemophilus influenza b (Hib)*
- *Infant mortality rate*

Early Development, including social and emotional development

- *Physical health and motor development*
- *Emotional problem/anxiety*
- *Hyperactivity/inattention*
- *Physical aggression/conduct problem*
- *Prosocial behaviour*
- *Language skills*

Safety and Security

- *Injury mortality rate*
- *Injury hospitalization rate*

Family

- *Parental education*
- *Level of income*
- *Parental depression*
- *Tobacco use in pregnancy*
- *Family functioning*
- *Positive parenting*
- *Reading by adult*

Community

- *Neighbourhood satisfaction, safety, cohesion*

Physical Health

Healthy birth weight is seen as the key determinant of infant survival. Low birth weight babies are at higher risk of dying in their first year, and have a greater risk of disability and chronic medical difficulties in later life. Low birth weight is associated with poor maternal health, lifestyle, and economic

circumstances. High birth weight babies are also at higher risk for early death, although the mortality rate is less than that of low birth weight babies. While Saskatchewan's high birthweight is above the Canadian average, of the 13 provinces and territories, there are six with greater percentages of high birthweights than the percentage in Saskatchewan.

The low birthweight rate = (number of live births weighing <2500g/number of all live births) x 100

Low Birthweight Rate: % of Live Births with BW <2500g					
	1998	1999	2000	2001	2002
Canada	5.7	5.6	5.6	5.5	5.8
Saskatchewan	5.2	5.3	5.1	5.2	5.1

The data for low birth weight rates is derived from provincial and territorial vital statistics registries. (Canadian Vital Statistics Birth Database, Statistics Canada).

The high birthweight rate = (number of live births weighing >4000g/number of all live births) x 100

High Birthweight Rate: % of Live Births with BW >4000g					
	1998	1999	2000	2001	2002
Canada	12.8	13.1	13.8	13.6	13.2
Saskatchewan	14.8	14.9	16.1	16.3	16.2

The data for high birth weight rates is derived from provincial and territorial vital statistics registries. (Canadian Vital Statistics Birth Database, Statistics Canada).



Infectious diseases affect thousands of children each year, although the mortality rate across Canada has declined in recent years due to immunization programs and increased awareness of families and health professionals. Tracking the incidence of diseases such as measles, meningococcal disease and haemophilus influenza-b provides an indication of outbreaks of these diseases and the effectiveness of immunization practices.

The high rate for haemophilus influenza-b for 1998-99 in Saskatchewan relates to a spike in infections that year. The long-term trend shows that Saskatchewan has made great strides in decreasing the incidence of this disease and there has been only one reported case since 1998.

Number of Reported Incidences for three Vaccine-preventable Diseases

	1998		1999		2000		2001		2002		2003	
	Sask	Can	Sask	Can	Sask	Can	Sask	Can	Sask	Can	Sask	Can
Measles	0	7	0	9	0	80	0	7	0	1	0	6
Meningococcal	0	7	1	9	0	15	0	27	0	7	0	5
Hib	3	15	0	15	0	7	0	16	1	16	0	9

Rate per 100,000 children of Reported Incidences for three Vaccine-preventable Diseases

	1998		1999		2000		2001		2002		2003	
	Sask	Can	Sask	Can	Sask	Can	Sask	Can	Sask	Can	Sask	Can
Measles	0	.3	0	.5	0	3.7	0	.3	0	0	0	.3
Meningococcal	0	.4	1.2	.5	0	.7	0	1.3	0	.3	0	.2
Hib	5.8	.2	0	.8	0	.4	0	.9	1.6	.9	0	.5

For Measles and Meningococcal Group C Disease, numbers and rates include children 0 to 5 years of age; for Hib, rates include children 0 to 4 years of age.

Data for Measles, Measles, Meningococcal Group C Disease and Hib for 2002 and 2003 are provisional and subject to change.

Hib: Haemophilus Influenza type b disease (Hib data are based on confirmed cases reported through the Notifiable Diseases Surveillance System).

Source: Immunization and Respirator Infections Division, Centre for Infectious Disease Prevention and Control, Public Health Agency of Canada.

Infant mortality rates are accepted as one of the most important measures of child and maternal health status. A high rate is an indication of deficiencies in nutrition, socio-economic status, education or access to health care. Infant mortality is also strongly linked to maternal

factors such as level of education, age, smoking and drug or alcohol abuse during pregnancy. The infant mortality rate for Saskatchewan, while higher than the Canadian average, is consistent with the rate in both Alberta and Manitoba.

Infant Mortality Rate (per 1000 live births)

	1998	1999	2000	2001	2002	2003	2004
Saskatchewan	7.1	6.3	6.8	5.5*	5.7*	5.5*	5.9*
Canada	5.3	5.3	5.3	5.2	5.4	**	**

*Crude rate. Source: *Annual Report on Saskatchewan Vital Statistics 2004*

**Data not currently available.

Source: *Canadian Vital Statistics - Mortality Database, Summary List of Causes, Statistics Canada.*

Early Development

Ensuring that children are able to participate in positive and stimulating environments, and play-based learning promotes healthy child development. Positive childhood behaviours such as high positive social behaviour, low aggression, and emotional security help to assist children in educational achievement, and socioeconomic status. Although the frequency of negative behaviours is more prevalent in adolescence, significant levels of negative and positive social behaviour appear in early childhood. There are strong linkages between

emotional health in children with parenting styles and family functioning.

The Motor and Social Development scale consists of a set of 15 questions that measure dimensions of the motor, social and cognitive development of young children from birth through three years. The questions vary by age of the child. These questions are asked of the Person Most Knowledgeable (PMK) of the child.

Motor and Social Development - Children 0 - 3 Years

	Advanced (%)		Average (%)		Delayed (%)	
	Sask	Canada	Sask	Canada	Sask	Canada
1998-99	19.3	15.0	69.1	71.9	11.6	13.9
2000-01	14.3	13.1	71.9	72.6	13.9	14.3
2002-03	10.7	13.2	74.1	73.2	15.2	13.6

Source: *National Longitudinal survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-99), Cycle 4 - v2 (2000-01), and Cycle 5 (2002-03) Child Questionnaire. (While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it - Statistics Canada)*

Exclusions: Children aged 4-5 years; children living in the Territories; children living on reserve; children living in institutions.



In 2000-01, the National Longitudinal Survey of Children and Youth (NLSCY) questionnaire no longer included questions relating to prosocial behaviour. Instead, parents were asked questions about their baby's personal and social behaviour using a new instrument called 'Ages

and Stages' (ASQ). Parents were asked about their child's interaction with him or herself, with strangers, parents and objects such as toys. Although the two measures are different, they are both included in the Early Development - Emotional Health chart.

Early Development - Emotional Health: Children Ages 2 - 5

	Low Pro-social (%)		High Aggression (%)		High Hyperactivity (%)		High Emotional Problems (%)	
	Sask	Can	Sask	Can	Sask	Can	Sask	Can
1998-99	11.8	10.2	15.5	13.5	14.6	12.2	12.1	13.8
2000-01	16.7	16.0	16.6	12.6	14.8	15.1	17.9	17.8
2002-03	14.1	15.7	16.8	14.6	5.2	5.5	15.4	16.7

Emotional health is defined as the proportion of children aged 2-5 years who exhibit high levels of emotional and/or anxiety problems. Emotional problem/anxiety is one of a number of behaviour scales examined in NLSCY. The purpose of the behaviour scales is to assess the extent of the presence/absence of certain aspects of a child's behaviour. The questions associated with the behaviour scales are asked of the PMK of the child and do NOT represent professionally diagnosed problem behaviours.

Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-99), Cycle 4-v2 (2000-01), and Cycle 5 (2002-03), Child Questionnaire.

Exclusions: Children aged 0-1 years; children living in the Territories; children living on reserve; children living in institutions.



In the National Longitudinal Survey of Children and Youth, a question was asked about whom in the household was the person most knowledgeable (PMK) about the child participating in the survey. The intention was that the PMK, in most cases the mother, would provide information for all selected children in the household, as well as the sociodemographic information about herself and her spouse. The latter information was used to describe the socioeconomic situation of the child's family. Only one PMK was selected per household.

Scores on the Peabody Picture Vocabulary Test (PPVT-R) can be a good predictor of later school success. The test is designed to measure receptive or hearing vocabulary in either English or French. The test is administered by the interviewer directly to children aged four and five years whose PMK provided consent for the test to be administered to their child.

As such it can also provide some indication of school readiness by measuring verbal ability. There are strong linkages between PPVT-R scores and parenting style and education levels of parents. However, socioeconomic status is not closely linked to PPVT-R scores.

Peabody Picture Vocabulary Test – Revised (PPVT-R)

		Advanced (%)*		Average (%)		Delayed (%)
	Sask	Canada	Sask	Canada	Sask	Canada
1998-99	10.2	13.3	78.8	70.8	15.9	15.9
2000-01	13.2	13.9	74.7	68.8	12.1	17.4
2002-03	14.4	17.3	72.4	69.6	13.2	13.1

**Marginal data quality*

Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-99), Cycle 4-v2 (2000-01), Cycle 5 (2002-03) Child Questionnaire.

Exclusions: children aged 0-3 years; children aged 4-5 years for whom the PMK did not provide consent for the PPVT-R to be administered; children living in the Territories; children living on reserve; children living in institutions.

Safety and Security

Injury hospitalization and injury mortality rates are public health measures of reported cases of hospitalization or death due to injury. Safety equipment such as seat belts and car seats in automobiles, helmets for bicycles, motorcycles and snowmobiles, and lifejackets for watercraft have dramatically reduced injury and death. Considerable variation in injury mortality rates across Canada reflects differences regionally and locally in such things as lifestyle, farming or ease of access to emergency services in remote areas. Injury rates are also strongly linked to

income levels, family composition and household size.

Fortunately, relatively few young children die as a result of injury. Because of the small number of cases of injury requiring hospitalization or resulting in death, even a single case can greatly affect the rate per 100,000 cases. For that reason, the following two charts must be read with that caution in mind, as the small number of cases in Saskatchewan is a major limitation of this indicator.

Injury Hospitalization Rate (per 100,000 population less than 1 year of age)

	1997-98		1998-99		1999-00		2000-01		2001-02		2002-03*	
	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate
Canada												
All external causes	1,773	513.6	1,624	479.5	1,465	436.8	1,495	447.5	1,472	448.6		
Fall	738	213.8	702	207.3	658	196.2	658	197	643	195.9		
Suffocation	165	47.8	146	43.1	110	32.8	105	31.4	95	28.9		
Poisoning	110	31.9	96	28.9	68	20.3	90	26.9	106	32.3		
Contact with hot object	86	24.9	81	23.9	91	27.1	77	23.0	90	27.4		
Struck by/against an object, person or animal	53	15.4	53	15.6	49	14.6	49	14.7	38	11.6		
Natural environment	30	8.7	21	6.2	28	8.3	22	6.6	26	7.9		
Assault	242	70.1	179	52.8	157	46.8	201	60.2	179	54.5		
	1998-99		1999-00		2000-01		2001-02		2002-03*			
Saskatchewan	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate
All external causes	115	885.1	94	751.3	74	606.5	80	672.0	102	858.8		
Falls	36	280.2	38	303.7	21	172.2	28	235.2	32	269.4		
Suffocation			10	79.9	10	82.0	6	50.4				
Poisoning	12	93.4	8	63.9	6	49.2	7	58.8	10	84.2		
Contact with hot object	—	—	—	—	—	—	—	—	—	—		
Struck by/against an object, person or animal	—	—	—	—	—	—	—	—	—	—		
Natural environment	—	—	—	—	—	—	—	—	—	—		
Assault	22	171.2	12	95.9	13	106.6	16	134.4	20	166.4		

*Canada does not include data for Nunavut for 2002-03 - Nunavut did not report injury hospitalization data for that year.

Exclusions: Newborns are excluded. Out-patients and Emergency Department visits are excluded.

The injury hospitalization rate = (number of hospitalizations for treatment of injuries/total population aged less than one year) x 100,000.

Source: Canadian Institute for Health Information (CIHI) - hospital records.

Injury Hospitalization Rate (per 100,000 population 1 year of age to less than 5 years)

Canada	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate
All external causes	7,261	478.2	8,840	461.8	3,396	442.3	5,708	401.4	5,503	393.8
Fall	2,755	181.5	2,634	177.8	2,423	167.5	2,293	161.2	2,152	153.9
Suffocation	193	12.7	202	13.6	187	12.9	176	12.4	142	10.2
Poisoning	1,276	84.0	1,108	74.8	1,109	76.7	932	65.5	885	63.3
Contact with hot object	353	23.3	346	23.4	304	21.0	248	17.5	320	22.9
Struck by/against an object, person or animal	361	23.8	284	19.2	299	20.7	257	18.1	280	20.0
Natural environment	371	24.4	336	22.7	361	25.0	276	19.3	241	17.2
Assault	150	9.9	140	9.5	126	8.7	111	7.8	98	7.0
	1998-99		1999-00		2000-01		2001-02		2002-03*	
Saskatchewan	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate
All external causes	558	1,014.2	480	903.4	479	930.5	406	810.6	386	789.6
Falls	194	352.8	161	303.0	178	345.8	155	309.5	137	280.3
Suffocation	16	29.1	15	28.2	11	21.4	11	22.0	9	18.4
Poisoning	144	261.7	117	220.2	139	270.0	85	169.7	86	175.9
Contact with hot object	15	27.3	16	30.1	15	29.1	23	45.9	13	26.6
Struck by/against an object, person or animal	27	49.1	14	26.4	21	40.8	15	29.9	19	38.9
Natural/environment	24	43.6	16	30.1	21	40.3	14	28.0	12	24.5
Assault	18	32.7	24	45.2	14	27.2	21	41.9	14	28.6

*Canada does not include data for Nunavut for 2002-03 - Nunavut did not report injury hospitalization data for that year.

Exclusions: Newborns are excluded. Out-patients and Emergency Department visits are excluded.

The injury hospitalization rate = (number of hospitalizations for treatment of injuries/total population aged less than one year) x 100,000.

Source: Canadian Institute for Health Information (CIHI) - hospital records.

Injury mortality not available at this time.

Injury Hospitalization Rate (per 100,000 population less than 1 year of age)

	1998-99		1999-00		2000-01		2001-02		2002-03*	
Canada	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate
All external causes	1,773	513.6	1,624	479.5	1,465	436.8	1,495	447.5	1,472	448.6
Fall	738	213.8	702	207.3	658	196.2	658	197	643	195.9
Suffocation	165	47.8	146	43.1	110	32.8	105	31.4	95	28.9
Poisoning	110	31.9	96	28.9	68	20.3	90	26.9	106	32.3
Contact with hot object	86	24.9	81	23.9	91	27.1	77	23.0	90	27.4
Struck by/against an object, person or animal	53	15.4	53	15.6	49	14.6	49	14.7	38	11.6
Natural environment	30	8.7	21	6.2	28	8.3	22	6.6	26	7.9
Assault	242	70.1	179	52.8	157	46.8	201	60.2	179	54.5
	1998-99		1999-00		2000-01		2001-02		2002-03*	
Saskatchewan	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate
All external causes	115	895.1	94	751.3	74	606.9	80	672.0	102	858.8
Falls	36	280.2	38	303.7	21	172.2	28	235.2	32	269.4
Suffocation			10	79.9	10	82.0	6	50.4		
Poisoning	12	93.4	8	63.9	6	49.2	7	58.8	10	84.2
Contact with hot object	—	—	—	—	—	—	—	—	—	—
Struck by/against an object, person or animal	—	—	—	—	—	—	—	—	—	—
Natural/environment	—	—	—	—	—	—	—	—	—	—
Assault	22	171.2	12	95.9	13	106.6	16	134.4	20	168.4

*Canada does not include data for Nunavut for 2002-03 - Nunavut did not report injury hospitalization data for that year.

Exclusions: Newborns are excluded. Out-patients and Emergency Department visits are excluded.

The injury hospitalization rate = (number of hospitalizations for treatment of injuries/total population aged less than one year) x 100,000.

Source: Canadian Institute for Health Information (CIHI) - hospital records.

Injury Hospitalization Rate (per 100,000 population 1 year of age to less than 5 years)

	1998-99		1999-00		2000-01		2001-02		2002-03*	
Canada	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate
All external causes	7,261	478.2	6,840	461.8	6,396	442.3	5,708	401.4	5,503	393.6
Fall	2,755	181.5	2,634	177.8	2,423	167.5	2,293	161.2	2,152	153.9
Suffocation	193	12.7	202	13.6	187	12.9	176	12.4	142	10.2
Poisoning	1,276	84.0	1,108	74.8	1,109	76.7	932	65.5	885	63.3
Contact with hot object	353	23.3	346	23.4	304	21.0	249	17.5	320	22.9
Struck by/against an object, person or animal	361	23.8	284	19.2	299	20.7	257	18.1	280	20.0
Natural environment	371	24.4	336	22.7	361	25.0	275	19.3	241	17.2
Assault	150	9.9	140	9.5	126	8.7	111	7.8	98	7.0
Saskatchewan	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate
All external causes	558	1,014.2	480	903.4	479	930.5	406	810.6	386	789.6
Falls	194	352.6	161	303.0	178	345.8	155	309.5	137	280.3
Suffocation	16	29.1	15	28.2	11	21.4	11	22.0	9	18.4
Poisoning	144	261.7	117	220.2	139	270.0	85	169.7	86	175.9
Contact with hot object	15	27.3	16	30.1	15	29.1	23	45.9	13	26.6
Struck by/against an object, person or animal	27	49.1	14	26.4	21	40.8	15	29.9	19	38.9
Natural/environment	24	43.6	16	30.1	21	40.8	14	28.0	12	24.5
Assault	18	32.7	24	45.2	14	27.2	21	41.9	14	28.6

*Canada does not include data for Nunavut for 2002-03 - Nunavut did not report injury hospitalization data for that year.

Exclusions: Newborns are excluded. Out-patients and Emergency Department visits are excluded.

The injury hospitalization rate = (number of hospitalizations for treatment of injuries/total population aged less than one year) x 100,000.

Source: Canadian Institute for Health Information (CIHI) - hospital records.

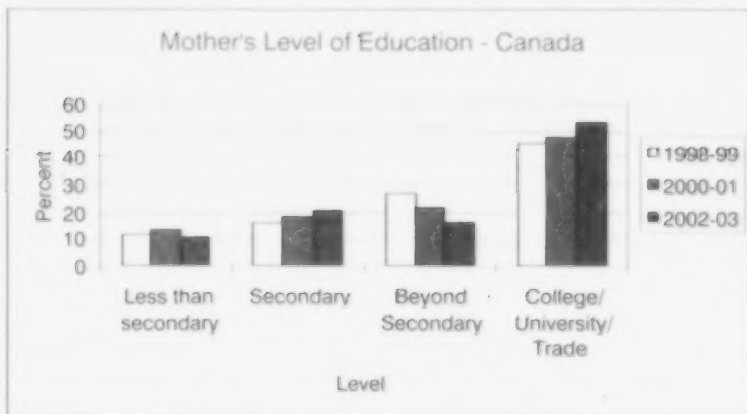
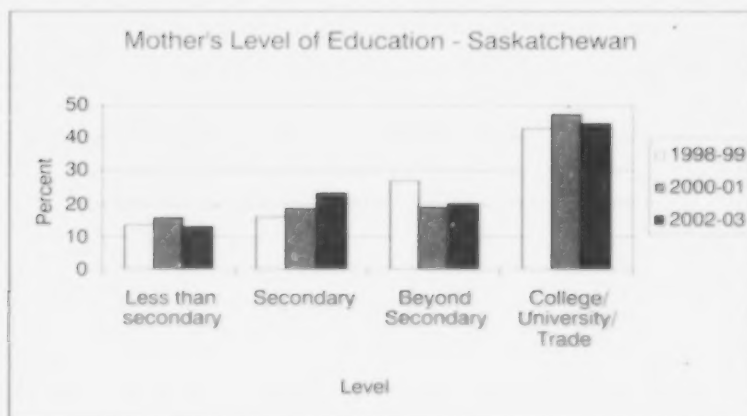
Injury mortality not available at this time.

Family

"One of the most persistent and pervasive findings of the research on human development is that people's health and well-being are related to socioeconomic factors such as income, occupational prestige, and level of education". Similarly, children and youth growing up in families of lower socioeconomic status tend to do less well in academic pursuits, are less likely to complete secondary school, and tend to be less successful in entering the labour market than those from more advantaged backgrounds. The relationship between children's outcomes and family income is so firmly

entrenched in our understanding of human development that the term 'children at risk' has almost become synonymous with 'children living in poverty.'

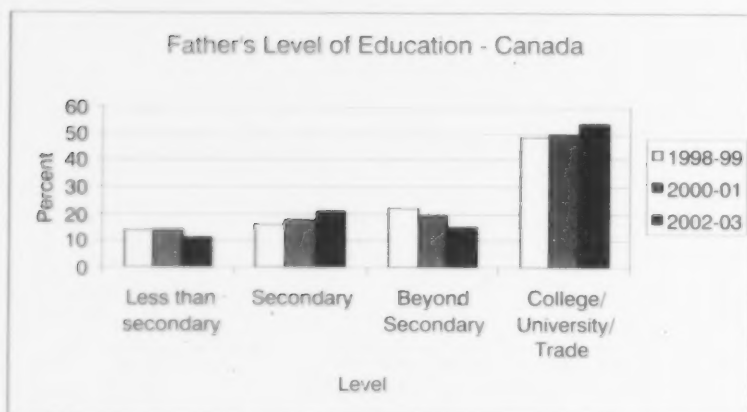
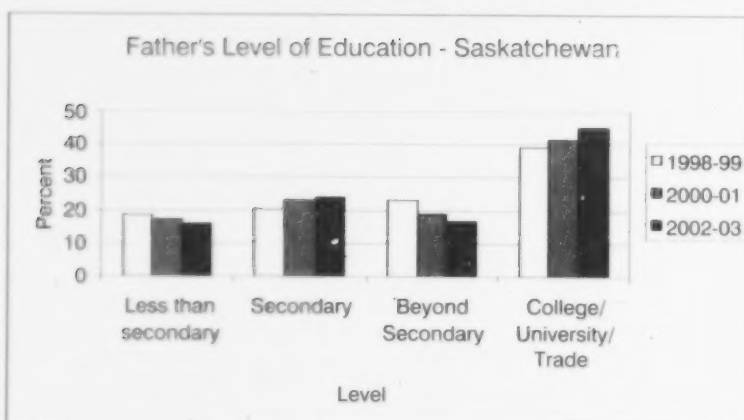
...Although there may be a gradient associated with family income, we often encounter children from poor families who have been remarkably resilient, and children from affluent families who have behavioural or academic difficulties." (J. Douglas Willms, ed., *Vulnerable Children*, 2002, University of Alberta Press, page 8)



Definition: The highest level of education attained by the mother of children aged 0 - 5 years. This indicator refers to the biological, step, adoptive or foster mother who is living with the child. Note that this indicator will not represent the education status of mothers of children living in male-headed single-parent households.

Exclusions: Children whose PMK (or spouse of the PMK) is not a biological, step, adoptive or foster mother; children living in the Territories; children living on reserve; children living in institutions.

Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-99), Cycle 4-v2 (2000-01), and Cycle 5 (2002-03) Child Questionnaire.



Definition: The highest level of education attained by the father of children aged 0 - 5 years. This indicator refers to the biological, step, adoptive or foster father who is living with the child. Note that this indicator will not represent the education status of fathers of children living in female-headed single-parent households.

Exclusions: Children whose PMK (or spouse of the PMK) is not a biological, step, adoptive or foster father; children living in the Territories; children living on reserve; children living in institutions.

Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-99), Cycle 4v2 (2000-01), and Cycle 5 (2002-03) Child Questionnaire.

Low Income Cut Off Rates (LICOs) are income thresholds determined by analyzing family expenditure data obtained through the Survey of Labour Market and Income Dynamics, Statistics Canada, which samples information from a large survey of Canadian families. The LICO is the threshold below which families will likely devote a larger share of their income to the basic necessities of food, shelter and clothing than the average

family would. LICOs are not poverty lines. Because LICOs are relative measures of all income levels, considerable variation can occur from year to year. Beginning with this report, Saskatchewan will show trends in the percent of families with young children living below the LICO, using a three year moving average in addition to the yearly data provided by Statistics Canada. This evens out the yearly fluctuation while making trends over time more evident.

Low Income Rates (Percentage) Families with children under 6 years of age Below After Tax LICO (1992 base)				
	Saskatchewan		Canada	
1998	-	11.2	-	15.0
1999*	14.2*	13.3	16.2*	15.5
2000*	13.7*	15.4	15.2*	15.6
2001*	11.8*	11.8	14.3*	13.5
2002*	12.2*	8.7	13.4*	13.9
2003	-	16.6	-	12.7

Source: Survey of Labour and Income Dynamics (SLID) - Statistics Canada, Reference Years 1998, 1999, 2000, 2001, 2002, and 2003.

Exclusions: Children Living in the Territories.

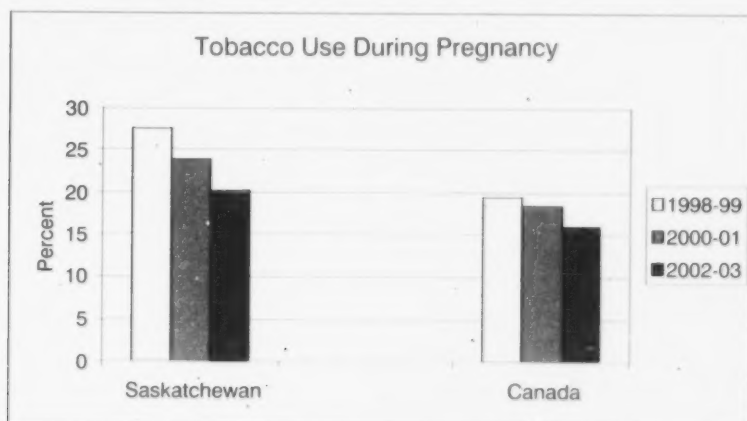
* Three year moving average.





Tobacco use is the leading cause of preventable illness and death in Canada. While second-hand smoke is a serious health risk for everyone, fetuses and young children are particularly susceptible to the harmful effects of tobacco smoke in their environment. These effects include stillbirth, low birth weight, increased risk of sudden infant death syndrome, reduced lung development and increased incidence and

severity of respiratory illness. Reducing the number of women who smoke during pregnancy is an important public health objective. Smoking rates are highest among young women, low income earners and those in remote communities. There is also a correlation between smoking and higher rates of alcohol and drug abuse.



Definition: The proportion of children aged 0 - 1 years whose mother smoked during her pregnancy with the child.

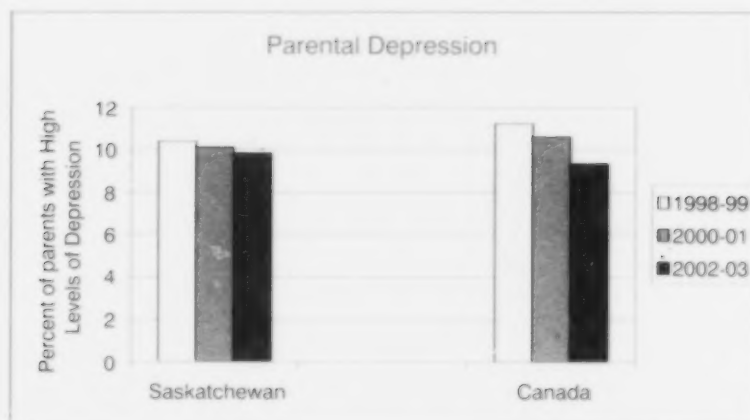
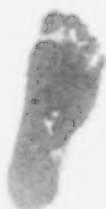
Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-99), Cycle 4-v2 (2000-01), Cycle 5 (2002-03) Child Questionnaire.

Exclusions: Children aged 2 - 5 years; children living in the Territories; children living on reserve; children living in institutions.



Depressed parents are typically withdrawn, tired, despondent and pessimistic about the future. Children raised by depressed parents (particularly mothers) are more likely to have behaviour problems and poor cognitive

development. Children in low-income households more often have a depressed parent than children in middle and upper income families.



Definition: The proportion of children aged 0 - 5 years whose PMK (Person Most Knowledgeable) exhibits high symptoms of depression. The Depression Scale in the NLSCY represents a condensed version of the Depression Rating Scale (CES-D). This scale measures the occurrence and severity of symptoms associated with depression in the public at large and does not represent the occurrence of clinically diagnosed depression.

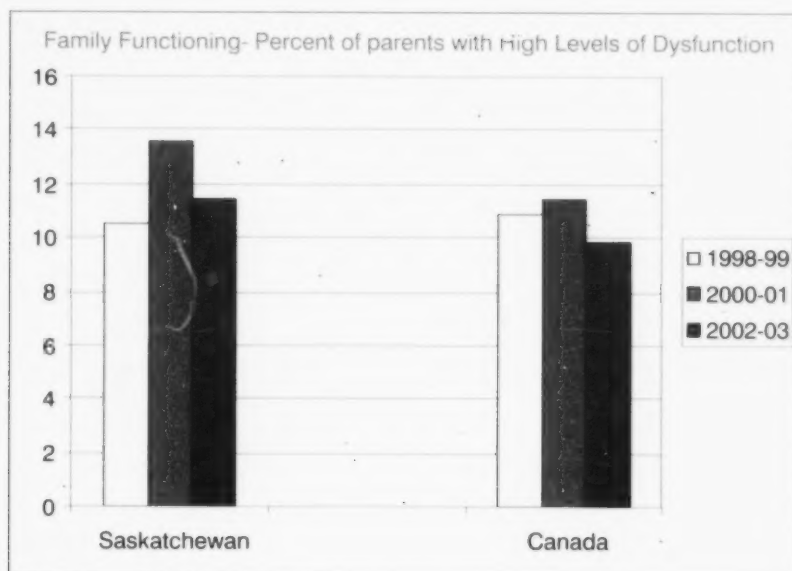
Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-99), Cycle 4-v2 (2000-01), Cycle 5 (2002-03) Child Questionnaire.

Exclusions: Children living in the Territories; children living on reserve; children living in institutions.



In the NLSCY, family functioning was measured by asking parents a number of questions about problem solving practices, expressive communication, decision-making and levels of acceptance. Families with low

scores exhibit a high degree of dysfunctional behaviour. This kind of family environment increases the likelihood of childhood behaviour and emotional problems such as aggression and anxiety.



Definition: The proportion of children aged 0 - 5 years in families with high levels of dysfunction. The family functioning scale provides a global assessment of family functioning (including problem-solving, communication, roles, affective involvement, affective responsiveness and behaviour control) and indicates the quality of relationships between family members. This scale is administered to either the person most knowledgeable (PMK) about the child or the spouse/partner. The scale does not reflect a clinical diagnosis.

Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-99), Cycle 4-v2 (2000-01), Cycle 5 (2002-03) Child Questionnaire.

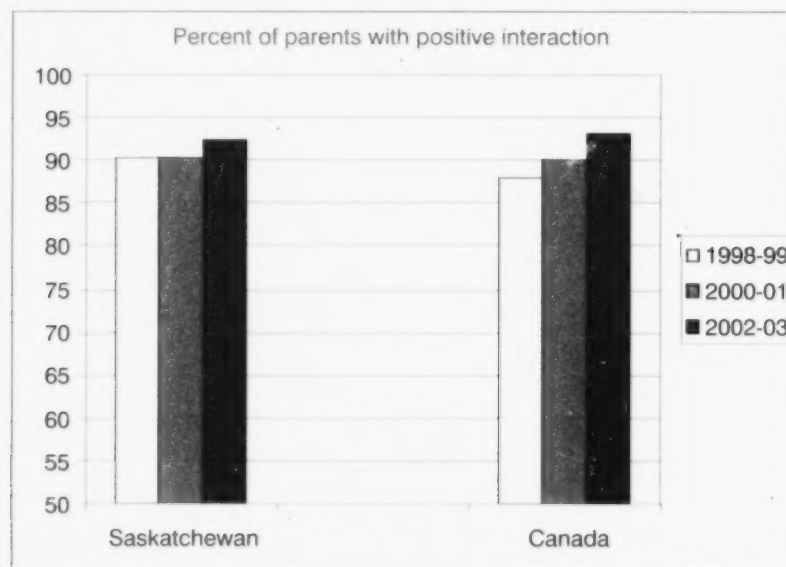
Exclusions: Children living in the Territories; children living on reserve; children living in institutions.





In the NLSCY, parents were asked how often they engaged in a number of positive parenting interactions with their children. These interactions included praise, playing together and laughing together. Children whose parents do

not frequently engage in these types of positive interactions have a higher risk for poor motor and social development and the development of negative social behaviours as they grow up.



Definition: The proportion of children aged 0 - 5 years whose parents do not exhibit low positive interaction with the child. Positive interaction is a parenting style that is captured in the NLSCY. The purpose of the parenting scales is to measure certain parental behaviours. The questions assessing parenting styles were administered to the person most knowledgeable (PMK) about the child or spouse/partner of the PMK.

Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-99), Cycle 4-v2 (2000-01), and Cycle 5 (2002-03) Child Questionnaire.

Exclusions: Children living in the Territories; children living on reserve; children living in institutions.





Adults who read to their children have a positive impact on children's educational outcomes. In general, the more frequently a child is read to,

the more positive the benefits in vocabulary and reading comprehension during the earlier years of school.

How often Adult Reads to Child or Listens to Child Read - Percentage

		1998-99	2000-01	2002-03
Saskatchewan	A few times a week or less	29.8	11.2*	9.1
	Daily	59.3	22.0	24.1
	Many times each day	10.9	66.8	66.8
Canada	A few times a week or less	30.3	11.0	10.1
	Daily	58.2	23.6	22.7
	Many times each day	11.5	65.4	67.3

**Marginal data quality: While this estimate meets Statistics Canada's quality standards, there is a high level of error associated with it.*

Definition: Distribution of children aged 0 - 5 years by how often an adult reads to the child or listens to the child read. This indicator refers to the exposure of the child to reading activities with a parent or another adult. Therefore, this indicator should not be interpreted to refer specifically to parent-child interactions.

Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-99), Cycle 4-v2 (2000-01), and Cycle 5 (2002-03) Child Questionnaire.

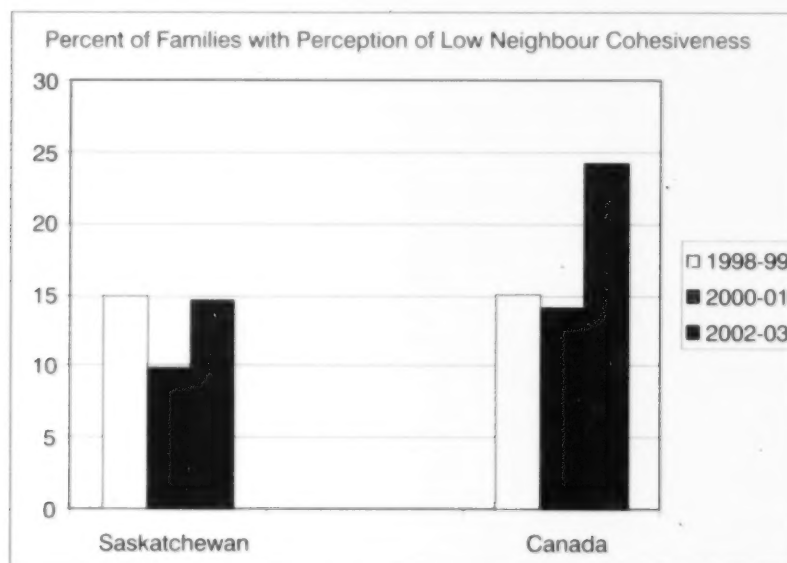
Exclusions: Children living in the Territories; children living on reserve; children living in institutions.



Community-Related Indicators

The neighbourhood cohesiveness score is based on perceptions of trust of neighbours, the presence of adults that are role models for children, cooperation of neighbours in dealing with problems, watching out for children's safety

and keeping an eye on neighbours' property when they are away. Children growing up in neighbourhoods with low levels of cohesiveness are less likely to be ready for school.



Definition: The proportion of children aged 0 - 5 living in neighbourhoods with low neighbourhood cohesion, as judged by the PMK. The purpose of the neighbourhood scales is to assess the extent of the presence/absence of certain neighbourhood characteristics. In particular, the neighbourhood cohesion scale can be used to measure the social unity of a neighbourhood. All questions about the neighbourhood were administered to the PMK or spouse/partner of the PMK.

Source: National Longitudinal Survey of Children and Youth, Master File (Statistics Canada), Cycle 3 (1998-99), Cycle 4-v2 (2000-01), Cycle 5 (2002-03) Child Questionnaire.

Exclusions: Children living in the Territories; children living on reserve; children living in institutions.







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